

***United States Court of Appeals
for the Second Circuit***



**BRIEF FOR
APPELLANT**

77-7 (09)7

To be argued by
DAVID L. BIRCH

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

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THE MEDICAL SOCIETY OF THE STATE OF :
NEW YORK, a New York not-for-profit :
corporation, MORTON M. KOFF, M.D., :
MILTON ROSENBERG, M.D., and JANE :
DOE, :

Plaintiffs-Appellees, :

-against- :

PHILIP TOIA, as Commissioner of the :
Department of Social Services of :
the State of New York, and ROBERT :
P. WHALEN, M.D., as Commissioner of :
Health of the State of New York, :

Defendants-Appellants. :

-----X

On Appeal from the United States District Court
for the Eastern District of New York

BRIEF FOR DEFENDANTS-APPELLANTS

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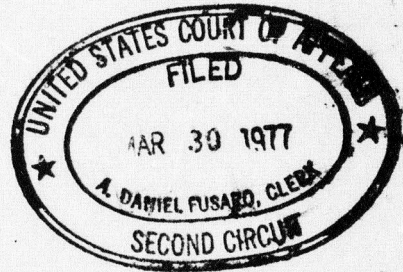


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THE MEDICAL SOCIETY OF THE STATE OF	:
NEW YORK, a New York not-for-profit	:
corporation, MORTON M. KOFF, M.D.,	:
MILTON ROSENBERG, M.D., and JANE	:
DOE,	:
 Plaintiffs-Appellees,	:
 -against-	: 77-7097
 PHILIP TOIA, as Commissioner of the	:
Department of Social Services of	:
the State of New York, and ROBERT	:
P. WHALEN, M.D., as Commissioner of	:
Health of the State of New York,	:
 Defendants-Appellants.	:

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On Appeal from the United States District Court
for the Eastern District of New York

BRIEF FOR DEFENDANTS-APPELLANTS

Statement

This is an appeal from an order of the United States District Court for the Eastern District of New York (Pratt, J.), dated January 25, 1977 preliminarily enjoining the implementation and enforcement of subdivision five(a), (b), (c) and (e) of Section 365-a of the Social Services Law of the State of New York. The order was based on findings of fact and conclusions of law set forth in a memorandum and order dated January 18,

1977, as amended by the Court's order of January 20, 1977.

On March 22, 1977, this Court denied defendants-appellants' motion for a stay pending appeal.

Questions Presented

1. Did the District Court improperly find that the complaint alleged a constitutional question sufficiently substantial to sustain its jurisdiction under 28 U.S.C. § 1343(3)?

2. Do the physician plaintiffs or their Medical Society have standing to assert the rights of their patients?

3. Are the rights of plaintiffs Doe and Ortega ripe for adjudication?

4. Does NYSSL § 365-a(5) violate the medicaid statute or HEW's regulations thereunder?

5. Did the District Court abuse its discretion in issuing a preliminary injunction?

Statement of Facts & Proceedings Below

On March 30, 1976, Chapter 76 of the Laws of New York, 1976 was signed into law, amending New York Social Services Law § 365-a. Plaintiffs, an association of physicians, two members of the association and two patients, sought, on constitutional and statutory grounds, to enjoin the enforcement of so much of Chapter 76 that (1) limits reimbursable hospital care to twenty days per illness [NYSSL § 365-a(2)(b)]; (2) limits reimbursable pre-operative hospital care to one day [NYSSL § 365-a(5)(d)]; and (3) limits reimbursement for surgery to emergency and urgent surgery, to certain specific procedures based on medically indicated risk factors and medically necessary surgery where delay would increase medical risk and to procedures otherwise deferrable except that two physicians state that deferral for six months or more may jeopardize life or essential function or cause severe pain [NYSSL § 365-a(5)(a)(b)(c) and (e)].

The court below refused to issue a preliminary injunction against (1) and (2), but did enjoin (3).

That part of Chapter 76 enjoined by the Court

states:

NYSSL § 365-a

"5(a) Medical assistance shall include surgical benefits for emergency or urgent surgery for the alleviation of severe pain, for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated.

(b) Medical assistance shall include surgical benefits for certain surgical procedures which meet standards for surgical intervention, as established by the state commissioner of health on the basis of medically indicated risk factors, and medically necessary surgery where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention.

(c) Medical assistance shall include surgical benefits for other deferrable surgical procedures specified by the state commissioner of health, based on the likelihood that deferral of such procedures for six months or more may jeopardize life or essential function, or cause severe pain; provided, however, such deferrable surgical procedures shall be included in the case of in-patient surgery only when a second written opinion is obtained from a physician, or as otherwise prescribed, in accordance with regulations established by the state commissioner of health, that such

surgery should not be deferred.

* * *

(e) Medical assistance shall not include any in-patient surgical procedures or any care, services or supplies related to such surgery other than those authorized by this subdivision. . ."

No evidentiary hearing was held by the court below but depositions and affidavits were presented. Dr. Edward Alchek, a physician specializing in plastic and reconstructive surgery deposed on behalf of the plaintiffs (A. 174).** Dr. Alchek deposed that plaintiff Ortega had voluntarily sought surgery (A. 183-84), that his condition would cause damage to his eye if not operated on, and that vision is an essential function (A. 189).

* The regulations promulgated by the Department of Health pursuant to this statute are set forth in the Joint Appendix, pp. 65ff.

** Page references preceded by "A" refer to the joint appendix.

Dr. Morton M. Koff, a plaintiff, testified that he does not perform surgery (A. 224). The two general surgeons to whom he refers patients requiring surgery will not accept any surgery that might be excluded by the new law because they refuse to do the paperwork (A. 226). Therefore, under the new statute, Dr. Koff sends his patients to the County hospital (A. 226).

Dr. Robert Seinfeld, a partner of plaintiff Dr. Rosenberg, both practitioners of obstetrics and gynecology, deposed that he and Dr. Rosenberg no longer accept new medicaid patients except for dire emergencies referred by a local physician because

"we're being bombed with the thought of paperwork. It means hiring more help. It means waiting. If I ask for a second opinion, which I really don't believe is needed to begin with, because it doesn't fit the categories that were present, if I decided to go and circumvent a procedure and ask for a second opinion, by the time I got it it would be another month and you have to get through the hospital to get the patient in.

"It's just too much of a hassle. It's hamstringing our practice." (A. 209).

Dr. Seinfeld further deposed that he had made no request for plaintiff Doe's admission to a hospital because his understanding of the law, and he told plaintiff Doe that he could not take care of her (A. 212).

Douglas Evans, Director of Utilization Control for the New York State Medicaid Program, deposed on behalf of the defendants, that Chapter 76, implemented since the beginning of July, 1976, had been followed by hospitals without significant difficulty (A. 239). He further deposed that the State had made reimbursement for cases similar to those described by plaintiff-patients Doe and Ortega (A. 244).

The affidavit of Dr. Eugene G. McCarthy, presented on behalf of the defendants, states that several medical insurance programs require the insured to have a second consultation prior to admission for in-hospital elective surgery, i.e., essentially all non-emergency surgery, that in the mandatory program, one out of seven and one-half screened patients had

surgery permanently deferred; that that findings justifies the adoption of the requirement of a second opinion for deferrable surgery, and that that improves the quality of care and provides effective cost utilization (A. 269-72).

Frank T. Cicero, M.D., Second Deputy Commissioner of the New York State Department of Health stated that there was no indication that the plaintiff physicians had made any effort to determine whether there was coverage in the situations related with respect to the patient plaintiffs and that considerations other than medical necessity dictated their actions (A. 334). Dr. Cicero further stated that reimbursement had been made for procedures alleged by the plaintiffs to be unavailable; that the condition of plaintiff Doe, on the facts stated, would constitute a covered benefit, and that, with respect to plaintiff Ortega, there was no indication that established procedures had been followed and surgery then denied (A. 334-36).

Dr. Cicero further stated that medicaid patients have nearly two and one-half times more surgery than the general population (A. 336).

J. Raymond Diehl, Jr., the Acting Deputy Commissioner of the Division of Medical Assistance of the New York State Department of Social Services, stated that plaintiff Koff had failed to avail himself of procedures to obtain a second opinion or administrative review (A. 326). He further stated:

"The Department of Social Services and the Department of Health, in consultation with a number of practitioners and professional groups, have implemented Chap. 76 in a manner consistent with its purpose of requiring the second opinion, not in all surgical situations, but only in those situations which can be identified as being medically necessary in some cases and unnecessary in other cases, depending on individual circumstances."
(A. 327).

He added further that the cost to the State of enjoining the implementation of those parts of Chapter 76 subject to this action would be \$65 million/year (A. 329). He further explained that:

"Clearly, 10 NYCRR 85.1 and 2 provide for immediate treatment for persons ex-

hibiting obvious medical necessity. Only where there is clearly a question of medical necessity depending on the condition of the individual is a second opinion required under 10 NYCRR 85.3. The State of New York will not categorically refuse to provide medicaid for any type, group or description of surgery. The State will, however, require a second confirming opinion to protect its indigent citizens from needless suffering in certain established areas." (A. 330).

Dr. James D. Wharton, Assistant Commissioner of the Department of Health and director of the Division of Medical Standards, stated a substantial portion of costs result from over utilization (A. 247); that a program of second opinions could cut down significantly on unnecessary procedures (A. 248), that in 1974, there were 2.4 million unnecessary surgeries in the United States leading to 11,900 unnecessary deaths (A. 248); that prior to the enactment of Chapter 76, reimbursement was provided for electrolysis, operations to increase breast size, tattoo removal and unnecessary hysterectomy.

tomies. In 1974, for medicaid eligibles, there were 18,716 operations per 100,000 persons while for the total United States population there were 7,940 operations per 100,000 persons (A. 251). The purpose of Chapter 76 is high quality control and to prevent unnecessary program use to control program costs (A. 252).

Hugh O'Neill, Deputy Commissioner for Program and Policy for the Department of Social Services, stated that plaintiff Doe was immediately eligible for surgery (A. 264) and that on the facts given it appeared that plaintiff Ortega was eligible for reimbursable surgery (A. 265). He further stated:

"The purpose of Chapter 76 of the Laws of 1976 is to further certain legitimate interests of New York State; namely to limit unnecessary surgery to protect patients in the medicaid program and attempt to limit medicaid costs in response to an emergency fiscal crises of staggering proportions being faced by the State and local governments (C. 76, L. 76, section 1)." (A. 265)

Opinion of the District Court

In its memorandum and order dated January 18, 1977, the District Court (Pratt, J.), refused to enjoin NYSSL § 365-a(2)(b) and § 365-a(5)(d), found that the Medical Society has standing and could assert the rights of its members patients, that the court had subject matter jurisdiction under 28 U.S.C. § 1343(3) and preliminarily enjoined the enforcement of NYSSL § 365-a(5)(a)(b)(c) and (e) on the ground that it conflicted with 42 U.S.C. § 1396a(a)(13).

POINT I

THE DISTRICT COURT IMPROPERLY
FOUND THAT THE COMPLAINT
ALLEGED A CONSTITUTIONAL
QUESTION SUFFICIENTLY
SUBSTANTIAL TO SUSTAIN ITS
JURISDICTION UNDER 28 U.S.C.
§ 1343(3).

It is now well settled, and the District Court correctly found, that where the court has jurisdiction over a constitutional claim, it must first exercise its pendant jurisdiction over the statutory claim. Hagans v. Lavine, 415 U.S. 528 (1974); Schneider v. Whaley, 541 F. 2d 916 (2d Cir., 1976), affd. on rehearing ___ F. 2d ___ (1975 Slip Ops., p. 6121, December 22, 1976).

It is equally settled that before the court can exercise its jurisdiction under 28 U.S.C. § 1343 and exercise its pendant jurisdiction that the action must involve a substantial constitutional issue.

Hagans v. Lavine, supra; Andrews v. Maher, 525 F. 2d 113 (2d Cir., 1975). Where the purported constitutional issue is insubstantial, the court is ousted of jurisdiction Goosby v. Osser, 409 U.S. 512 (1973).

The District Court concluded that it had subject matter jurisdiction since the patient-plaintiffs had alleged that the second opinion requirement of NYSSL § 365-a(5)(c) violated their "constitutional right to privacy . . . especially where the surgery sought is of a highly personal nature." (A. 23).

The District Court based its jurisdiction on the fact that the plaintiffs' privacy argument found support in Roe v. Ingraham, 403 F. Supp. 931 (S.D.N.Y., 1975).

Roe v. Ingraham, supra, has been reversed by a unanimous court, Whalen v. Roe, ___ U.S. ___, 45 U.S.L.W. 4166 (February 22, 1977). The Court

stated: /

"[D]isclosure of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient. [Footnote omitted]. Requiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy." 45 U.S.L.W. at 4169.

The Court also indicated that the doctor's claimed right has no greater strength than that of his patient and that where the statute "merely made the physician's work more laborious or less independent without any impact on the patient, [the statute] would not have violated the constitution." 45 U.S.L.W. at 4170, n. 33.

Even prior to Whalen v. Roe, supra, the Supreme Court had recognized a constitutionally protected right of privacy only in the few very limited areas involving the right to marital privacy, Griswold v. Connecticut, 381 U.S. 479 (1965), the use of contra-

ceptive devices, Eisenstadt v. Baird, 405 U.S. 438 (1972), and the right to terminate pregnancies, Roe v. Wade, 410 U.S. 113 (1972) and Doe v. Bolton, 410 U.S. 179 (1972). The Supreme Court has never extended the fundamental right of privacy to encompass the simple doctor-patient relationship. This right has been limited to relationships which involve the most intimate phases of personal life having to do with sexual intercourse. Rosenberg v. Martin, 478 F. 2d 520 (2d Cir., 1973).

Chapter 76 operates with as minimal interference with the patient's alleged right to privacy as is possible under the circumstances. All information obtained by the physician offering a second opinion remains confidential. N.Y. Ed. Law § 6527(3), CPLR 4504, 42 U.S.C. § 1396a(a)7, 45 C.F.R. 205.50. In Association of American Physician and Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill., 1975), affd. 423 U.S. 975 (1975), a 3-judge court held that a guarantee of confidentiality was sufficient to protect a patient's right to privacy.

The District Court thus improperly based 28 U.S.C. § 1343 jurisdiction on the patient-plaintiff's

right to privacy, a right, under the circumstances here that is clearly insubstantial.

POINT II

THE PHYSICIAN PLAINTIFFS OR
THEIR MEDICAL SOCIETY HAVE
NO STANDING TO ASSERT THE
RIGHTS OF THEIR PATIENTS.

The physician plaintiffs, who perform surgery,* and their Medical Society may have standing to allege a violation of the medicaid statute. Singleton v. Wulff, ___ U.S. ___, 44 U.S.L.W. 5213 (July 1, 1976); National Union of Hospital and Health Care Employees v. Carey, Dock. No. 76-7203, p. 2411 (2d Cir., March 18, 1977), but the court below incorrectly held that they may assert the rights of their patients. Since it is the rights of patients and not physicians that the federal and state Medicaid statutes at issue here further and since the interests of physician and patient are opposed, the physician plaintiffs and the Medical Society may not challenge NYSSL § 365-a(5).

* Plaintiff Koff admittedly performs no surgery (see Koff deposition, A. 224), and thus has no pecuniary interest in that part of § 365-a that limits surgery reimbursement.

The plurality in Singleton v. Wulff, supra, stated that to determine whether any person may assert the rights of a third party, "it may be that in fact the holders of those rights . . . will be able to enjoy them regardless of whether the in-court litigant is successful or not" 44 U.S.L.W. at 5215. If this is true, then the litigant should not be permitted to assert the right of the third party.

The litigant also should not be permitted to assert the right of a third party where the litigant would not be an effective proponent of the third party's rights. The necessary premise here is that the two parties desire the court to construe the right in the same manner and that there is no obvious conflict between the two parties.

The closeness of the relationship between physician and patient here is far from patent as it was in Singleton v. Wulff, where it was beyond question that the woman wanted the abortion. Her doctor wanted to provide it and the State statute would not provide reimbursement for it.

It is beyond question here that responsible

State officials stated that those in similar circumstances to the patient plaintiffs had received reimbursable surgery for their conditions. (See, Evans deposition, A. 244; Affidavits of Cicero, A. 334-36 and O'Neill, A. 264-65.) It is clear that plaintiffs Doe and Ortega desire the operations. It is not clear that their physicians have any desire to provide those operations since they never attempted to ascertain whether the State would pay for them (Seinfeld deposition, A. 212; Cicero affidavit, A. 334). The physicians of plaintiffs Doe and Ortega have an interest in ensuring that they not receive the operations complained of since their factual patterns make sympathetic litigation. However, in light of the continuous assertion by the State below that those in similar circumstances have received reimbursable operations, it is clear that the physician plaintiffs and patient plaintiffs have an adverse interest, and the physicians should not be permitted to assert the patients' rights.

The physician plaintiffs should not be permitted to assert the rights of any patients, not merely those of Doe and Ortega, because NYSSL § 365-a

(5) was designed not merely to carefully ration very limited State and local funds but also to ensure quality control by avoiding unnecessary surgery that has led to death. If medicaid patients, the poorest of all United States residents, are receiving 2 1/2 times as much surgery as the general population, the possibility of countless unnecessary surgeries is clear. NYSSL § 365-a(5) attempts to prevent surgeons from performing unneeded surgery. Surgeons should not be permitted to assert the rights of those patients upon whom they perform needless surgery.

Dr. Seinfeld, plaintiff Dr. Rosenberg's partner, stated that they had stopped accepting medicaid patients because "we're being bombed with the thought of paperwork" (A. 209). Similarly, plaintiff Dr. Koff testified that the surgeons to whom he refers his patients will not accept any surgery that may be excluded by the new law because they refused to do the paperwork (A. 226). These physicians can hardly have the same interest as their patients whose interest is to have necessary surgery no matter how much paperwork their physicians have to fill out first.

Section 1396a(a)(13)(B), on which the District Court relied to invalidate NYSSL § 365-a(5), states that "A state plan for medical assistance must provide in the case of individuals receiving [certain federally subsidized aid] for the inclusion of at least the care and services listed in clauses (1) through (5) of Section 1396d(a) of the title."

The Court then relied on § 1396d(a)(5) to find that the plaintiff patients are entitled to "physicians' services furnished by a physician." Clearly these rights are rights of patients, not physicians, and the physician plaintiffs may not assert them.

POINT III

THE RIGHTS OF PLAINTIFFS DOE
AND ORTEGA ARE NOT RIPE FOR
ADJUDICATION.

As amply pointed out, ante, pp. 7-11, the State has consistently maintained that those in similar circumstances to the patient plaintiffs have received reimbursable operations. The patient plaintiffs have not made an application for surgery or for the permissible administrative review of any adverse decision.

See 10 NYCRR 85.3.

Plaintiffs have not been denied an operation based on anything done by the defendants or their agents. This action is untimely, premature and lacks the concreteness, certainty and strict necessity required before the federal courts will dispose of the constitutional issue. Socialist Labor Party v. Gilligan, 406 U.S. 583 (1972); Thorpe v. Housing Authority of Durham, 393 U.S. 268 (1969); Rescue Army v. Municipal Court, 331 U.S. 549 (1947). This necessity cannot occur until the State defendants have acted with respect to patient plaintiffs' applications.

In Hagans v. Wyman, 462 F. 2d 928 (2d Cir., 1972), on remand, ___ F. Supp. ___ (E.D.N.Y., 1972), revd. and remanded 471 F. 2d 347 (2d Cir., 1973), revd. sub. nom. Hagans v. Lavine, 415 U.S. 528 (1974), this Court, in remanding a challenge to a regulation of the New York State Department of Social Services, stated:

"Since it is not yet clear how the state will interpret or implement its recoupment regulation, there is ' . . . the need for some further procedure, some further contingency of application or interpretation, whether

judicial, administrative or executive . . . to make [ripe] the issue sought to be presented to the Court.' Poe v. Ullman, 367 U.S. 497, 528, 81 S. Ct. 1752, 1769, 6 L.Ed. 2d 989 (1961) (Harlan, J. dissenting). According, before holding state and federal welfare regulations in conflict, '. . . the appropriate course is to withhold judicial action pending reprocessing, [under New York fair hearing procedures] of the determinations here in dispute.' Richardson v. Wright, 405 U.S. 208, 209, 92 S. Ct. 788, 789, 31 L.Ed. 2d 151 (1972)."

In Hagans, a regulation of the Department was being attacked, so its policy was not entirely unknown to the Court. A fortiori, the present case is not yet ripe for adjudication, since plaintiffs point to no concrete denial of their right to an operation.

POINT IV

NYSSL § 365-a(5) DOES
NOT VIOLATE THE MEDICAID
STATUTE OR HEW'S REGULA-
TIONS THEREUNDER.

The District Court erroneously found that the limitation and review procedures set forth in NYSSL § 365-a(5)(a)(b)(c) and (e) are in conflict

with 42 U.S.C. § 1396a(a)(13)(B) and (C) and 42 U.S.C. § 1396d(a)(5). Section 42 U.S.C. § 1396a(a)(13)(B) and (C) requires that a State plan provide for the services listed in § 1396d(a)(5). Such services are "physicians' services furnished by a physician," § 1396d(a)(5).

In District of Columbia Podiatry Society v. District of Columbia, 407 F. Supp. 1259 (D.C.D.C., 1975), the Court stated:

"Title XIX is a welfare assistance program with limited funding. It is not an insurance program such as Medicare. Even an insurance program (let alone an assistance program) cannot provide coverage for all possible health services. Therefore, it is necessary for Medicaid funds to be used in the most economical manner possible, [footnote omitted] and it has been left to the States, operating within the Federal guidelines, to make such economic determinations." 407 F. Supp. at 1264.

The Court further stated that no provider of medical services is compensated under Medicaid for all the services that he may legally perform.

The court below also ignored those parts of the Medicaid Statute and regulations that explicitly require the State have a plan for quality control.

It is clear that the Social Security Act requires that physicians' services be furnished to all eligible individuals. However, these services are not to be furnished under every and all circumstances. The Social Security Act and the regulations promulgated pursuant to it place specific limitations upon this general requirement.

42 U.S.C. § 1396a(a)(3) requires a State plan to

"provide such methods and procedures relating to the utilization of . . . care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services . . ."
(Emphasis added)

42 U.S.C. § 1396a(a)(30) requires a State plan to

"provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but

not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care; . . ."

42 U.S.C. § 1396a(a)(33)A requires a State plan to

"provide that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan . . . for review . . . of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan . . ."

Similarly, 45 C.F.R. 249.10(a)(5)(i) permits limitation of services in the following manner:

". . . the State may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. Appropriate limits may be placed on services

based on such criteria as medical necessity or those contained in utilization or medical review procedures." (Emphasis added)

and 45 C.F.R. 249.10(b)(1) defines in-patient hospital services as

"those items and services ordinarily furnished by the hospital . . . and which has in effect a utilization review plan applicable to all patients who receive medical assistance under Title XIX of the Act which meets the requirement of Section 1861(k)* of the Social Security Act unless a waiver has been granted by the Secretary."

It is clearly demonstrated from these provisions that the State need only supply physician and in-patient hospital services when these services become medically necessary. Indeed, this is at the very heart of the purpose of Chapter 76. It is designed, and it operates to guarantee, that patients are not being subjected to needless surgeries or needless periods of hospitalization. It also guarantees that the State does not exhaust its preciously scarce resources on these unnecessary services.

All medically necessary surgeries will be

* 42 U.S.C. § 1395(k).

covered under the regulatory framework established under Chapter 76. By its very meaning, a medically necessary surgical procedure is one in which, under the circumstances of the specific case, a failure to perform the surgery may result in a curtailment of the patient's ability to function adequately in our society. It will also involve a consideration of the risks associated with the procedure as compared to the benefits to be derived from it. From this, it can be seen that any medically necessary surgery will always fall within the catchall of Social Services Law § 365-a(5)c. For example, plaintiffs describes lipoma to the Court below. If a thirty year old woman is inflicted with this condition, it inhibits her ability to engage in sexual intercourse which may threaten her ability to partake in "essential functions." Thus, this surgery would be medically necessary and would be covered by § 365-a(5)c. In addition, the condition might cause the patient to suffer emotional trauma. This too would be threatened interference with her ability to partake in essential functions and would cause the surgery to become medically necessary. However, if the condition is suffered by a widow in

her 80's, there is no interference with her ability to partake in "essential functions" and the surgery, especially considering the risks involved, is not medically necessary. Since it is not medically necessary, it will not be a covered procedure under Chapter 76. It is important to establish, in addition, that the second opinion requirement attached to some provisions of Chapter 76 will never result in a failure to cover medically necessary surgery. Rather, it will only insure, for the protection of the patient and the State, that the surgery is indeed medically necessary.

In sum, under the regulatory framework established by Chapter 76, all medically necessary physician and in-patient hospital services will be provided. This is all that is required by the federal laws and regulations, and Chapter 76 is therefore in conformity with them.

NYSSL § 365-a(5) and the control it places on surgery does nothing more than permitted by the Medicaid Statute itself: it "safeguard[s] against unnecessary utilization" (§ 1396a[a][3] and

[30]) and establishes "a plan . . . for review . . . of the appropriateness and quality of care and services furnished to recipients of medical assistance." (§ 1396a[a][33]).

HEW regulations themselves permit such a limitation.* 45 C.F.R. § 249.10(a)(5)(i) permits limits based on "medical necessity."

The interpretation of "physicians' services" by the District Court requires government subsidization of various types of unessential surgery that the Medicaid Act clearly did not envision covering. New York does not generally provide sex change operations. Matter of Denise R. v. Lavine, 39 N Y 2d 279 (1976). Nor must such operations as those for tattoo removal, hair transplants, unnecessary tonsillectomies, adenoidec-
tomies or hysterectomies be covered by the Medicaid Act. The Court in District of Columbia Podiatry Society v. District of Columbia, supra, realized that the State may place administrative control on services provided.

* The court below made inappropriate use of HEW letters since HEW has taken no final position on the statute in issue. HEW's official position is that the statute is still under review. The letters are preliminary and were written prior to the enactment of the statute and the implementation of the regulations under the statute.

The State officials with the responsibility of interpreting and implementing the Act consistently stated below that those with immediate medical necessity will be immediately treated. Only where surgery is potentially unnecessary is a second opinion required. The Medicaid Statute requires no more.

POINT V

THE DISTRICT COURT ABUSED ITS
DISCRETION IN ISSUING A
PRELIMINARY INJUNCTION.

In what this Court has called "the familiar test of this circuit," Triebwasser & Katz v. American Tel. and Tel. Co., 535 F. 2d 1356 (2d Cir., 1976), the party desiring a preliminary injunction must make

"a clear showing of either (1) probable success on the merits and possible irreparable injury, or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly toward the party requesting the preliminary relief." Sonesta Int'l Hotels Corp. v. Wellington Associates, 483 F. 2d 247, 250 (2d Cir., 1973) (emphasis in original). It is equally familiar law that the granting of preliminary injunctive relief lies within the sound discretion of the District Court and will not be disturbed unless there is an abuse of that discretion. (citations omitted), or unless there

is a clear mistake of law. (citations omitted)" 535 F. 2d at 1358.

Where a governmental program is involved, the party requesting preliminary relief has a higher burden. The Supreme Court has expressed the view that where the public interest is concerned, interlocutory relief is properly withheld where the plaintiff cannot, if unsuccessful, compensate for the damage done to the public. Yakus v. United States, 321 U.S. 414 (1944). In Yakus, the Court stated: (321 U.S. 440-41)

"The award of an interlocutory injunction by courts of equity has never been regarded as strictly a matter of right, even though irreparable injury may otherwise result to the plaintiff. Compare Scripps-Howard Radio v. Federal Communications Comm'n, 316 U.S. 4, 10 and cases cited. Even in suits in which only private interests are involved the award is a matter of sound judicial discretion, in the exercise of which the court balances the conveniences of the parties and possible injuries to them according as they may be affected by the granting or withholding of the injunction. Meccano, Ltd. v. John Wanamaker, 253 U.S. 136, 141; Rice & Adams Corp. v. Lathrop, 278 U.S. 509, 514. And it will avoid such inconvenience and injury so far as may be, by attaching conditions to the award, such as the requirement of an injunction bond conditioned upon payment of any damage caused by the injunction if

the plaintiff's contentions are not sustained. Prendergast v. New York Telephone Co., 262 U.S. 43, 51; Ohio Oil Co. v. Conway, 279 U.S. 813, 815.

"But where an injunction is asked which will adversely affect a public interest for whose impairment, even temporarily, an injunction bond cannot compensate, the court may in the public interest withhold relief until a final determination of the rights of the parties, though the postponement may be burdensome to the plaintiff. (footnote omitted) Virginian Ry. Co. v. United States, 272 U.S. 658, 672-3; Petroleum Exploration Co. v. Public Services Comm'n, 304 U.S. 209, 222-3; Dryfoos v. Edwards, 284 F. 596, 603, affd. 251 U.S. 146; see Beaumont, S.L. & W. Ry. Co. v. United States, 282 U.S. 74, 91, 92. Compare Wisconsin v. Illinois, 278 U.S. 367, 418-21. This is but another application of the principle, declared in Virginian Ry. Co. v. System Federation, 300 U.S. 515, 552, that "Courts of equity may, and frequently do, go much farther both to give and withhold relief in furtherance of the public interest than they are accustomed to go when only private interest are involved."

Under similar circumstances to those presented here, this Court has only recently stated "With one New York County after another teetering on the brink of financial disaster because of State enforced Medicare and Medicaid contributions, (footnote omitted) adoption of appellants' proposed course of action could well furnish

the final impetus leading to financial chaos." National Union of Hospital and Health Care Employees v. Carey, supra, Slip Op. at 2418-19. It is uncontradicted that the cost to the State of the injunction below will be some \$65 million per year. The cost to individuals receiving unnecessary surgery cannot be calculated in dollars.

In contrast, the cost to the patient plaintiffs is nothing since those in similar circumstances have received reimbursable surgery. If Doe and Ortega would make proper application they would in all likelihood have no cause to complain.

In their own words, the cost to the plaintiff physicians is merely an increase in paperwork, a cost that pales with the financial cost to the financially pressed State and localities.

Plaintiffs clearly have not made a clear showing of probable success of the merits. Nor have they shown irreparable injury. Any balancing of the hardships assuredly tips in favor of the State, its localities and its citizens who should neither be required to pay for nor undergo needless and potentially

harmful surgery. The District Court both abused its discretion and made a clear mistake of law in granting plaintiffs a preliminary injunction.

CONCLUSION

THE ORDER OF THE DISTRICT COURT
ENJOINING THE IMPLEMENTATION OF
NEW YORK SOCIAL SERVICES LAW
§ 365-a(5)(a)(b)(c) and (e)
SHOULD BE REVERSED IN ALL
RESPECTS.

Dated: New York, New York
March 30, 1977

Respectfully submitted,

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ex hand by

Melba T. Caliano

AT 4¹⁰ pm CN 3-30, 1977